

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9579

CERTIFICATE OF DEATH

Reg. Dist. No.

09533

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RULE P.O. Box</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Greenby</u> Middle <u>Brooks</u> Last <u>Brooks</u>		4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-1880</u> 79 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm work</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
10a. BIRTHPLACE (State or foreign country) <u>md.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Georgiana Fields</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>11</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Marietta Green, Oxford, md.</u>		Address <u>---</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute upper respiratory infection</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>---</u> a. m. <u>19</u> p. m. <u>---</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/19</u> , 19 <u>59</u> , to <u>8/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/22</u> , 19 <u>59</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>L. J. Ehlsson</u> M.D.		PHYSICIAN'S NAME (Type) <u>L. J. Ehlsson</u>	
22a. BURIAL, CREMATION, or MOVING (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (city, town, or county) (State)
<u>BURIAL</u>	<u>8-25-59</u>	<u>Odd Fellow Lodge Cem</u>	<u>N.R. Oxford, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>As. B. Vashell</u>		24a. REC'D BY REGISTRAR <u>---</u> 24b. REGISTRAR'S SIGNATURE <u>---</u>	
ADDRESS <u>Easton, md.</u>		DATE <u>AUG 27 '59</u>	

CERTIFICATE OF DEATH

1875

Form with multiple lines for handwritten entry, including fields for name, age, sex, date of death, and cause of death. The text is mostly illegible due to fading and bleed-through.

Vertical text on the right margin, likely a filing or archival stamp, including the words "RECORDED" and "INDEXED".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9559 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FEDERALSBURG</u> 05X-2	
c. LENGTH OF STAY IN IB <u>20 DAYS</u>		d. STREET ADDRESS <u>RFD #2 Box 245</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA GERTRUDE BRUMMELL</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 17 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS TILGHAM</u>		14. MOTHER'S MAIDEN NAME <u>MARY PHILLIPS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>CHARLES BRUMMELL</u>		Address <u>FEDERALSBURG, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>330x</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic inflammatory disease, rt. lung, etiology unknown</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>unknown</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/2/59</u> to <u>8/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/16</u> , 19 <u>59</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u>8-19-59</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>202 Dover St.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FEDERAL HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton Son</u>		ADDRESS <u>Federalsburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9560

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09535

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		d. STREET ADDRESS 05X-2	
3. NAME OF DECEASED (Type or print) First HARRY Middle EDWARD Last BULLOCK		4. DATE OF DEATH Month AUGUST Day 12 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 17, 1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HUCKSTER		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE ALFRED BULLOCK		14. MOTHER'S MAIDEN NAME MARY MINER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 203-18-5356	
17. INFORMANT SON		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolyte imbalance DUE TO Phycho obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:25 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2195 Washington St Baltimore, MD DATE SIGNED Aug 59 ACTUAL SIGNATURE E. C. H. Schmidt M.D. E. C. H. Schmidt PHYSICIAN'S NAME (Type) E. C. H. Schmidt ADDRESS Easton 16, Maryland 22a. BURIAL, CREMATION, REMOVAL (Specify) Buried 22b. DATE THEREOF Aug 13/59 22c. NAME OF CEMETERY OR CREMATORY DENTON 22d. LOCATION (City, town, or county) (State) DENTON MD 23. FUNERAL DIRECTOR'S SIGNATURE J. V. Moorhead ADDRESS Son 24a. REC'D BY REGISTRAR DATE AUG 17 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kneal			

MEDICAL CERTIFICATION

080

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Md.
JAN 10 1910
CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color	
John Doe		45		Male		White		White	
Residence		Occupation		Cause of Death		Date of Death		Place of Death	
123 Main St		Teacher		Heart Disease		Jan 5 1910		Home	
Physician		Funeral Home		Burial Place		Interment		Remarks	
Dr. Smith		Doe & Sons		Cemetery		Buried		No other	
Signature		Witness		Registrar		County		State	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9580

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film G246 8-17-59 et
CERTIFICATE OF DEATH

09536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels	
3. NAME OF DECEASED (Type or print) First MARY Middle L. Last BUTLER		4. DATE OF DEATH Month August Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1868
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Mitchell, Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Boland		14. MOTHER'S MAIDEN NAME Catherine A. O'Donnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Catherine B. Jackson, St. Michaels		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic cardiovascular DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cachexia, generalized.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-27-1955 to 8-6-1959 , that I last saw the deceased alive on 8-6-1959 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, State) DATE SIGNED ACTUAL SIGNATURE Thymy M. Beeson Jr. M.D. St. Michaels Md PHYSICIAN'S NAME (Type) Thymy M. Beeson Jr. 8-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 10, 1959	
22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Bedford, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Hamberton Harrison		ADDRESS St. Michaels	
24a. REC'D BY REGISTRAR DATE AUG 10 '59		24b. REGISTRAR'S SIGNATURE Orthur S. Hines	

1935

9280

CERTIFICATE OF DEATH

County

Jefferson

Age

Infant

Residence - St. Louis

Funeral - St. Louis

Sex

Male

Color

White

Weight

Height

21

Dec. 22, 1935

Time

Place

Cause

USA

Illness, Influenza

Home

Dr. J. J. O'Donnell

Dr. J. J. O'Donnell

Dr. J. J. O'Donnell, St. Louis, Mo.

Dr. J. J. O'Donnell

Dr. J. J. O'Donnell

Dr. J. J. O'Donnell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9561
CERTIFICATE OF DEATH

09538

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>Near Chestnut Grove</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD JAMES DEW</u>				4. DATE OF DEATH Month Day Year <u>August 28 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1896</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST (Wholesale)</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>CONN. (Bridgeport)</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES DEW</u>				14. MOTHER'S MAIDEN NAME <u>ELLA Relyea</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>216-18-5981</u>		17. INFORMANT Address <u>Mrs. Flossie A. Dew, Federalsburg, Md., RFD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>28 Aug</u> , 19 <u>59</u> , to <u>28 Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>28 Aug</u> , 19 <u>59</u> , and that death occurred at <u>12:20 P M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Caroline Maryland</u>			
DATE SIGNED <u>28 Aug 59</u>							
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 31, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson and Son</u>				ADDRESS <u>Federalsburg</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Reed</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

2282

<p>NAME OF DECEASED [Faint handwritten name]</p>	
<p>AGE [Faint handwritten age]</p>	
<p>SEX [Faint handwritten sex]</p>	
<p>DATE OF BIRTH [Faint handwritten date]</p>	
<p>PLACE OF BIRTH [Faint handwritten place]</p>	
<p>DATE OF DEATH [Faint handwritten date]</p>	
<p>PLACE OF DEATH [Faint handwritten place]</p>	
<p>CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>DIAGNOSIS [Faint handwritten diagnosis]</p>	
<p>DATE OF EXAMINATION [Faint handwritten date]</p>	
<p>PLACE OF EXAMINATION [Faint handwritten place]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>DATE OF SIGNATURE [Faint handwritten date]</p>	
<p>PLACE OF SIGNATURE [Faint handwritten place]</p>	
<p>DATE OF FILING [Faint handwritten date]</p>	
<p>PLACE OF FILING [Faint handwritten place]</p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9562

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			
c. LENGTH OF STAY IN 1b <u>10h17 47min</u>				d. STREET ADDRESS <u>Hunting Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Yage</u> Middle <u>B</u> Last <u>Ellis</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1907 April 4</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Yage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>21-16-3903</u>		17. INFORMANT <u>Elizabeth Linda Ellis</u> Address <u>Easton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of the esophagus</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>29 Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>28 Aug</u> , 19 <u>59</u> , and that death occurred at <u>3:02 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>Arthur E. Evans</u>							
ACTUAL SIGNATURE <u>Arthur E. Evans</u> M.D.				PHYSICIAN'S NAME (Type) <u>ARTHUR E. EVANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cemetery</u>		22d. LOCATION (City, town, or township) <u>Philadelphia, Pa.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Clark</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	



9581

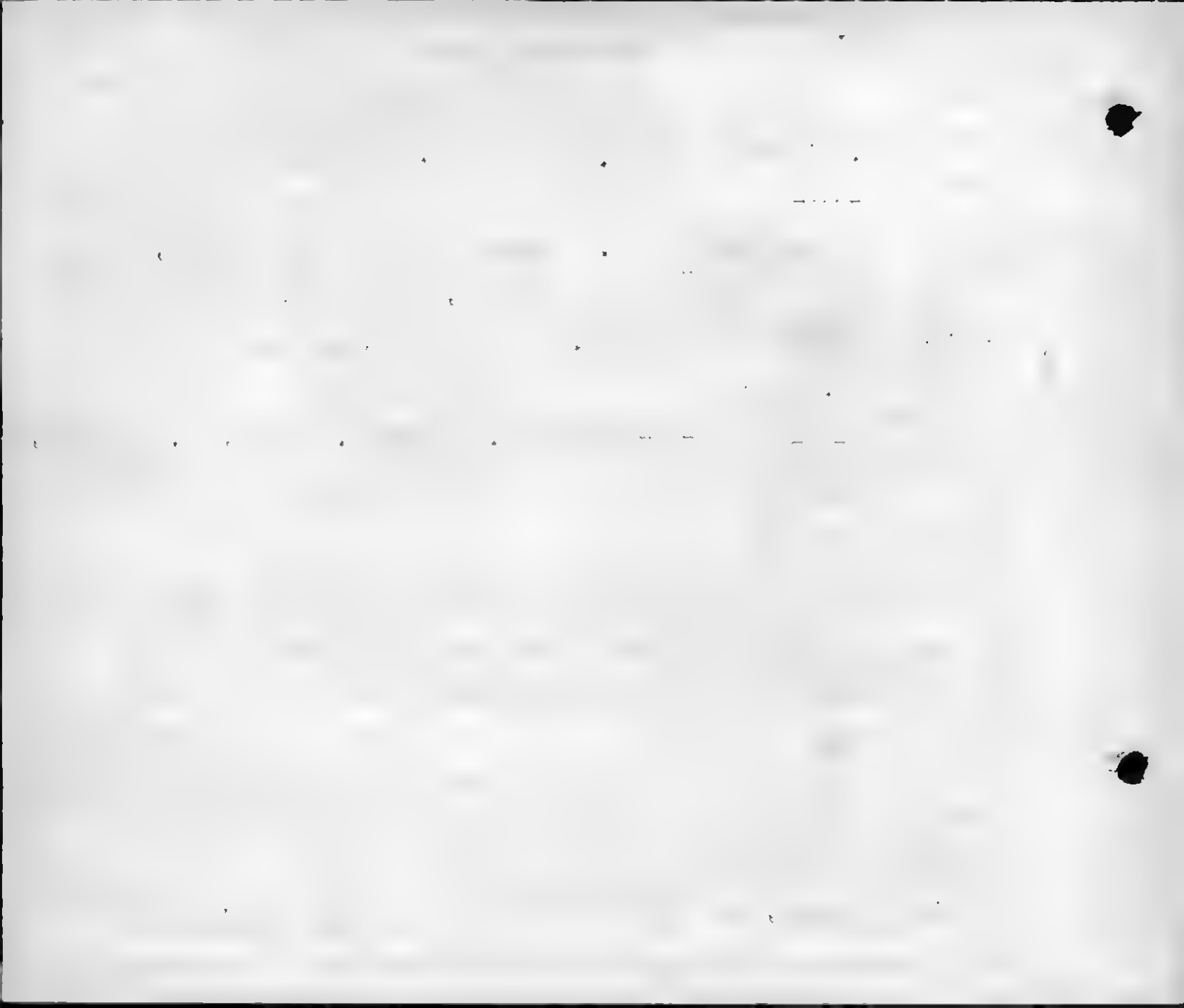
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels	
c. LENGTH OF STAY IN 1b 1 yr.		d. STREET ADDRESS Maple Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last GERMAN		4. DATE OF DEATH Month August 10, Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1893
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if not married) retired cable splicer		10b. KIND OF BUSINESS OR INDUSTRY C&P Tele Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles R. German		14. MOTHER'S MAIDEN NAME Fannie Lowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO 212-05-0940A	
17. INFORMANT Mrs. Charles E. German, St. Michaels, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Dis DUE TO (c) Arteriosclerosis - Generalized		INTERVAL BETWEEN ONSET AND DEATH 10 min 5 yr 10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 17, 1959 to 12 Aug 1959 , that I last saw the deceased alive on 11 Aug 1959 , and that death occurred at 10:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Paul Whitty M.D.		ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md	
DATE SIGNED 8-10-59			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 13, 1959	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Hanington Harrison ADDRESS St. Michaels		24a. REC'D BY REGISTRAR med	24b. REGISTRAR'S SIGNATURE Charles E. German



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9582

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Grim's Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jessie Middle Marshall Last Green		4. DATE OF DEATH Month August Day 19 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1889
9. AGE (In years less birthday) yrs 70		10. IF UNDER 1 YEAR Months 4 Days 11 Hours 11 Min 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Greenbury Marshall		14. MOTHER'S MAIDEN NAME Catherine Dean Hancock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 218 10 0077	
17. INFORMANT Mr. Lewis Green, Easton, Maryland		Address Prospect Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) a. i. t. d. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) 420.0 DUE TO (c) 420.0 INTERVAL BETWEEN ONSET AND DEATH 4 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/10/1959 to 8/19/1959 that I last saw the deceased alive on 8/10/1959 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 E. E. AVE. - Easton, Md. DATE SIGNED Oct 2 '59			
ACTUAL SIGNATURE W. Frampton Carroll		M.D. 11 E. E. AVE. - Easton, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/21/59	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll		24a. REC'D BY REGISTRAR DATE OCT 2 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Evans			



X-1
FOR STATE
HEALTH DEPT.

9563

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

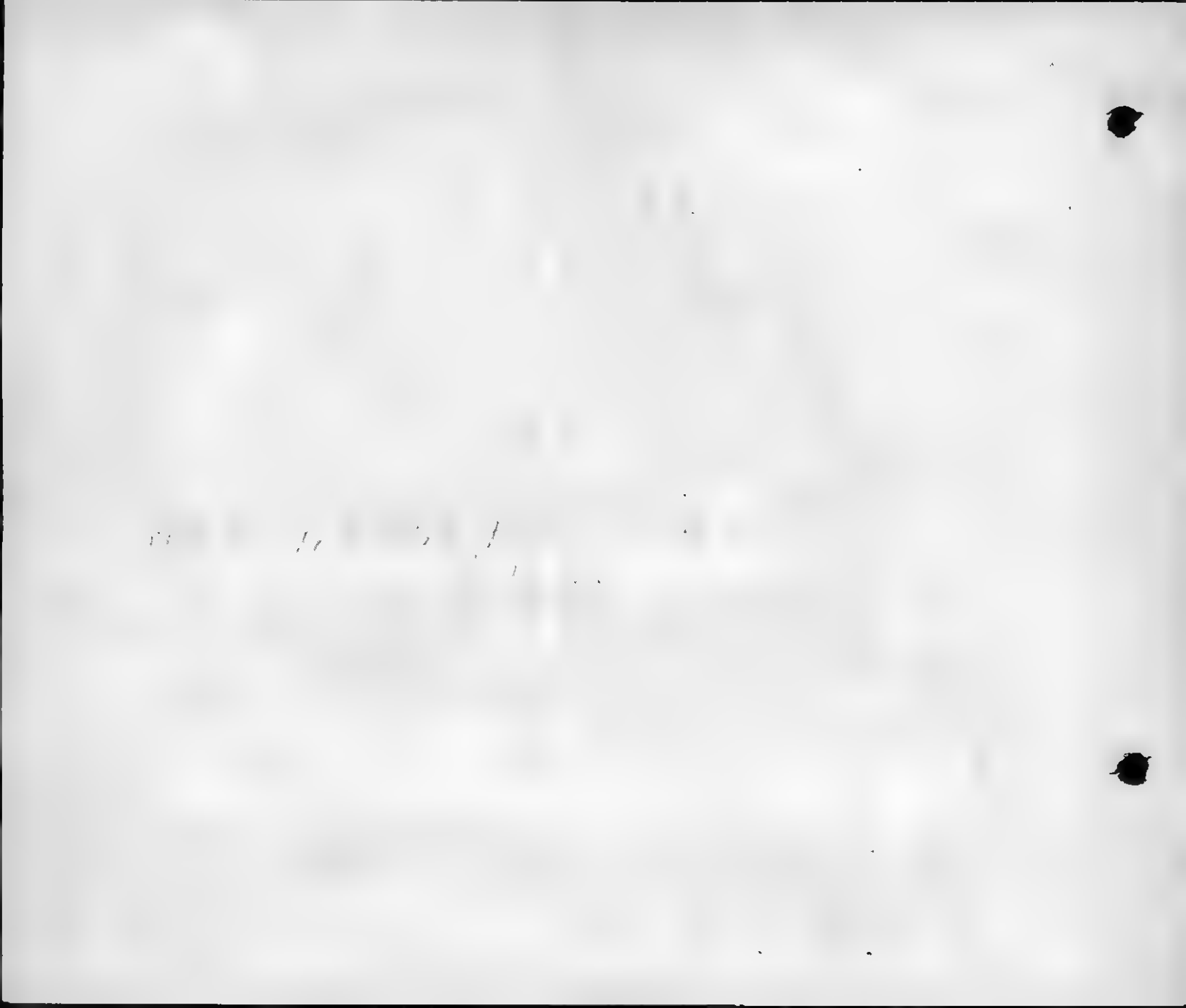
Item 3 Film 248 9-3-59 et

Reg. Dist. No.

09541

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Punta Gorda (Port Charlotte)</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>207 Normandy</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCY ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel Fairweather</u>		4. DATE OF DEATH <u>August 21 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 10, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Chaloner</u>		14. MOTHER'S MAIDEN NAME <u>Fairweather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Walter Smith - daughter -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain Injury</u> <u>816 X</u> DUE TO (b) <u>Automobile Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>± hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left forearm; Laceration a knee & left arm</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Motor v. m.v.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:00 a.m. 8/21/59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Irvin G. Hoyt MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/21/59</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial Aug 23/59</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Laurelwood Cemetery</u>	
22c. LOCATION (City, town, or county) (State) <u>Laurelwood Penn.</u>		22d. ADDRESS	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnie E. Leonard & Son</u>		24. REC'D BY REGISTRAR <u>Easton</u>	
24a. DATE AUG 25 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

9564

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10670

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>			
c. LENGTH OF STAY IN 1b <u>14 hrs.</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS Ruth E Harrison</u>				4. DATE OF DEATH Month Day Year <u>August 16 19 59</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8 1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Mr Joseph Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Virginia Jones, daughter - with no. 10.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute & chronic pyelonephritis</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>219 S. Westinghouse St. Easton 16, Maryland</u> <u>1949 59</u>							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.							
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Tilghman Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Thomas</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Paper-band 2 should be removed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9565

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09543

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Johns</u>		4. DATE OF DEATH Month Day Year <u>August 31 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 31, 1959</u>
9. AGE (In years last birthday) yrs. <u>9</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Rosetta Johns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital hypertrophy of the heart.</u> 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 31, 1959</u> , to <u>Aug 31, 1959</u> , that I last saw the deceased alive on <u>August 31, 1959</u> , and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Kirtz</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Denton, Md</u>	
PHYSICIAN'S NAME (Type) <u>EPaul Kirtz MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 4, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Virgil Moore & Son, Denton Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9566

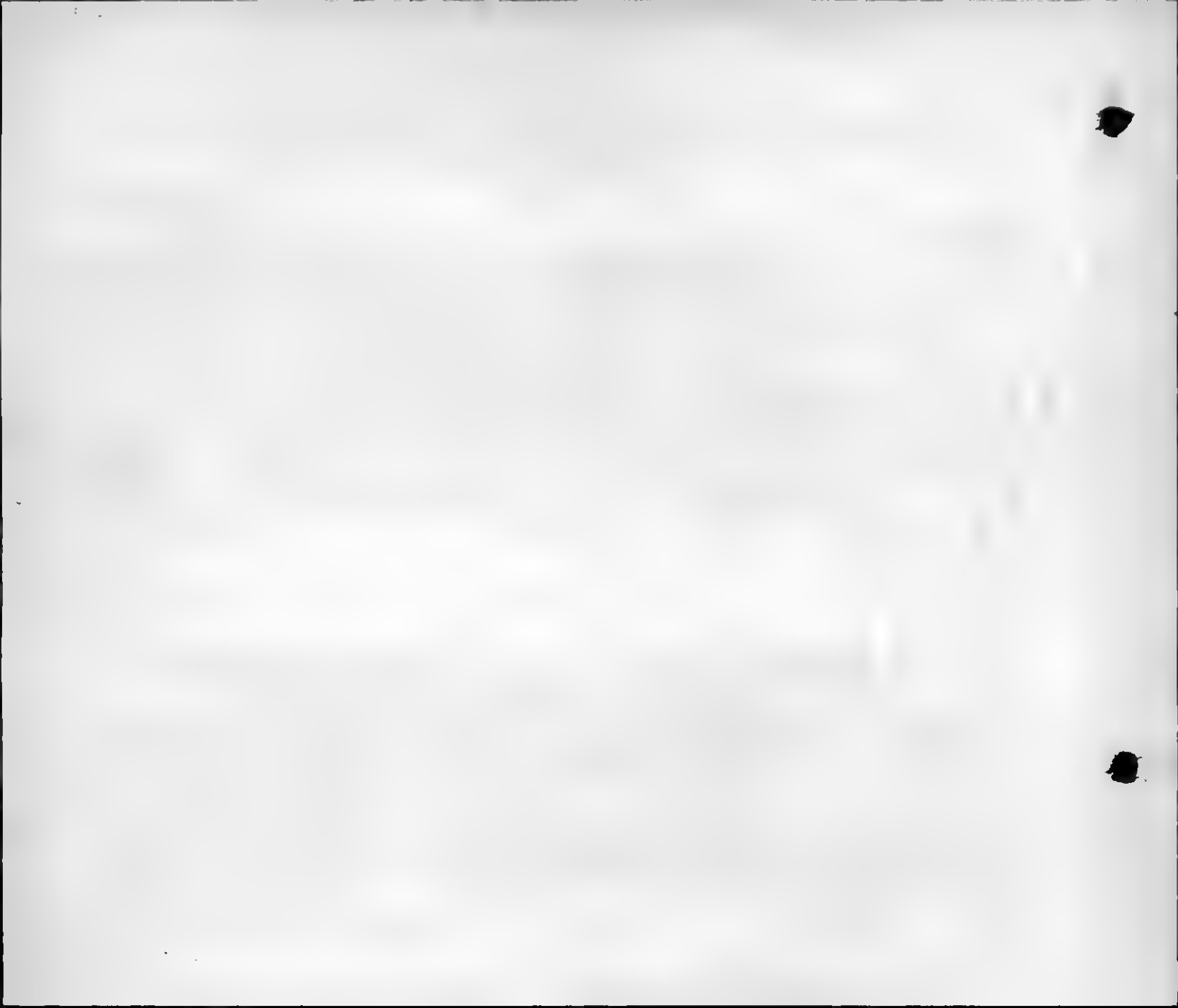
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09544

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u></u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 18 72</u>	9. AGE (In years last birthday) <u>87</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home farm tenant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Alice McDaniel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs Alice Brown, Queen Anne, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m.	Month <u></u> Day <u></u> Year <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>8-18</u> , 19 <u>59</u> , to <u>8-31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-30</u> , 19 <u>59</u> , and that death occurred at <u>12:12 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u> DATE SIGNED <u>9-1-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u></u>		PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown</u>		22d. LOCATION (City, town, or county) (State) <u>Hellsboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moore & Son, Inc.</u>				24a. REC'D BY REGISTRAR <u>SEP 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9567

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>36 Locust Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/85</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA GREEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>216-03-7530</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old cerebrovascular accident</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> that I last saw the deceased alive on <u>D.O.A. on arrival at Memorial Hospital 8-23-59</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.		ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		DATE SIGNED <u>8-27-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Danahill, Easton Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kirsch</u>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												09546			
9583 MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
Reg. Dist. No.															
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman				c. LENGTH OF STAY IN 1b 34 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) on a boat								d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles A. Lowery				4. DATE OF DEATH Month Aug Day 8 Year 19 59											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug 18, 1923		9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) water man				10b. KIND OF BUSINESS OR INDUSTRY oyster				11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wm. Joseph Lowery						14. MOTHER'S MAIDEN NAME Elsie M. Mattes									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWII				16. SOCIAL SECURITY NO. 216 18 2593		17. INFORMANT Mrs. Wm. J. Lowery, Tilghman, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution 9/4.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Heavy rain - Boarded boat being pumped out with electric pump											
20c. TIME OF INJURY Month, Day, Year 3:45 p.m. 8/8/59 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Knapps Narrows		20f. (City or town) Tilghman		(County) Talbot		(State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Louis M. Welty				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8-11-59							
EXAMINER'S NAME (Type) WELTY				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/11/59				22c. NAME OF CEMETERY OR CREMATORY Tilghman Methodist				22d. LOCATION (City, town, or county) (State) Tilghman, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J. L. L. Moore				ADDRESS Tilghman, Md.				24a. REC'D BY REGISTRAR DATE AUG 24 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			



9568

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10675

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u></u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Messick</u>		4. DATE OF DEATH <u>August 31 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16 1912</u>
9. AGE (In years last birthday) <u>47</u>		10. IF UNDER 1 YEAR <u></u> IF UNDER 24 HRS <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Hudson Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Dean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Essential hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>30 Aug 1959</u> , to <u></u> , that I last saw the deceased alive on <u></u> , 19 <u></u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Caroline, Maryland</u>	
DATE SIGNED <u>Sept 5</u>			
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>September 5, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>	22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Traubert & Son, Federalsburg, Md.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
DATE <u>SEP 10 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9569

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09547

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>403 South St</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md</u>	
3. NAME OF DECEASED (Type or print) <u>Carrie M. Rasin</u>		4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/32</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invalid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George P. Rasin</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Carrie Rasin</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Imbecile</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lewis M. WELTY</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELTY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-21-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richardson</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9570

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

119548

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Ridgely</u> <u>05X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Sheek</u>		4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4th 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA</u>	
11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Moses Gochman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wyandt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1P</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July</u> , 19 <u>59</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Caroline, Maryland</u> DATE SIGNED <u>12 Aug 59</u> ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. <u>Carlton E. Harris</u> PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REAUTOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>Aug 12, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Greenboro</u>		<u>Greenboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>J. V. Moore & Son</u>		<u>Aug 17 '59</u>	
ADDRESS <u>Baltimore, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Harris</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9571

CERTIFICATE OF DEATH

19550

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Duane</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Memorial Hospital</u>		d STREET ADDRESS <u>111</u>	
3 NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Snare</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1959</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 21 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>1</u> yrs. <u>5</u> Months <u>1</u> Days <u>5</u> Min
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ronald Burdette Snare</u>		14. MOTHER'S MAIDEN NAME <u>Pertins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>408-10-1000</u>	
17. INFORMANT <u>John</u>		Address <u>Pertins</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxemia</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>Placental Previa</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/21</u> , 19 <u>59</u> , to <u>8/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/21</u> , 19 <u>59</u> , and that death occurred at <u>1:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Quantico, Md.</u> DATE SIGNED <u>9/26/59</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>	22b. DATE THEREOF <u>8/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hrp</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanks</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

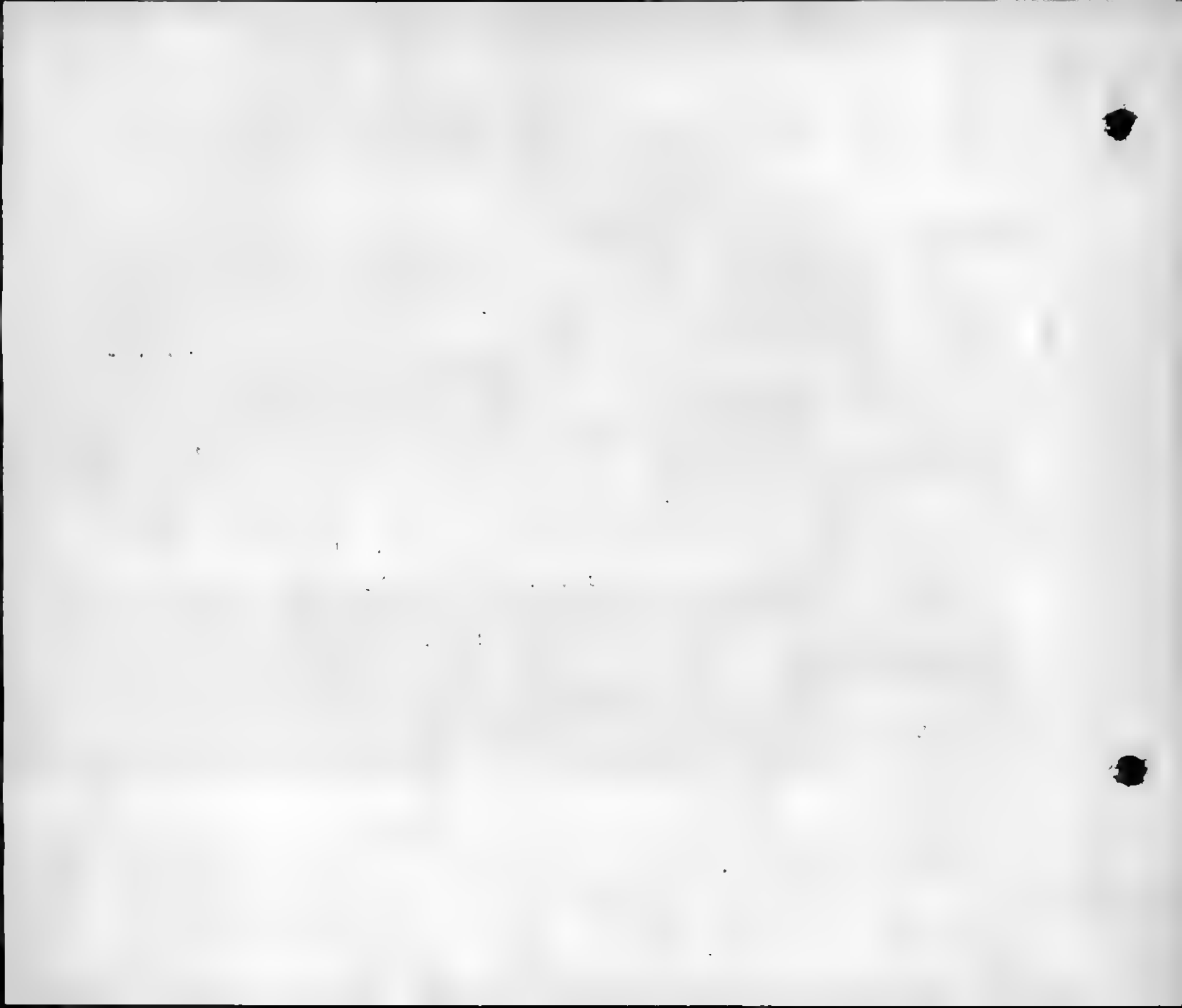
VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

9584 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09551

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NR OXFORD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxford	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas First Sparklin Middle Spar Last lin		4. DATE OF DEATH Month 8 Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/1890
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 6 Days 17 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Builder		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Sparklin		14. MOTHER'S MAIDEN NAME Ella Lowery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-4325	
17. INFORMANT Margaret Sparklin, Oxford, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (DIED ON BOAT WHILE FISHING—BODY DISCOVERED NEXT DAY) (c) PRIOR CARDIAC CONDITION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PRIOR CARDIAC CONDITION INTERVAL BETWEEN ONSET AND DEATH IMMED.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 8-22-59 Hour 1:10 m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CHOPTANK RIVER		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis S. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) LOUIS S. WELTY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 8-24-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/59	
22c. NAME OF CEMETERY OR CREMATORY Oxford		22d. LOCATION (City, town, or county) (State) Oxford, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulois, Greensboro, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



9572

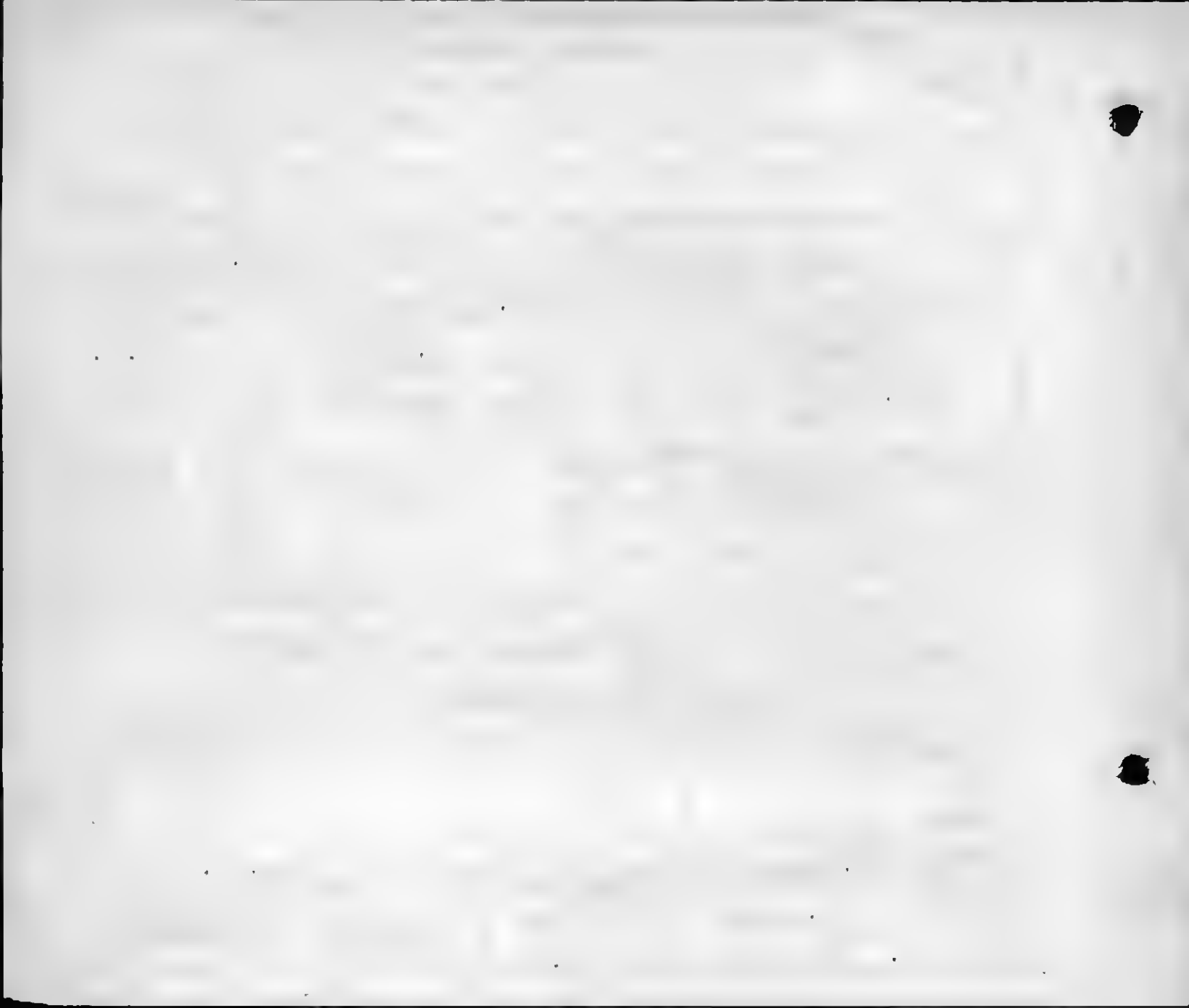
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09552

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Queen Anne ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY in lb 11 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home for Aged Women		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle MATILDA Last SPRY		4. DATE OF DEATH Month Aug. Day 19 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1874
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ran rooming house		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John L. Spry		14. MOTHER'S MAIDEN NAME Emma Cahoon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 4 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 July , 19 59 , to 19 Aug , 19 59 , that I last saw the deceased alive on 12 Aug , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 21 Aug 59			
ACTUAL SIGNATURE Maurice E. Newnam M.D.		Dr. Thurston Harrison	
PHYSICIAN'S NAME (Type) Dr. Thurston Harrison		Easton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 21, 1959	22c. NAME OF CEMETERY OR CREMATORY Church Hill Cemetery	22d. LOCATION (City, town, or county) (State) Church Hill, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR AUG 24 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kneass	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9573

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09553

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		d. STREET ADDRESS <u>Ridgely</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Starks</u> Last <u>Starks</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>2</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Starks</u>		14. MOTHER'S MAIDEN NAME <u>Eveline Tubbs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>013-22-8743</u>	
17. INFORMANT <u>Charles Starks</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>400.0</u> DUE TO <u>a.s.d.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ca of prostate</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Hour <u>19</u> o m. <u>p. m.</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1959</u> , to <u>Aug 18, 1959</u> , that I last saw the deceased alive on <u>8/18</u> , 1959, and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. E. C. M. D.</u> M.D.		DATE SIGNED <u>8/23/59</u>	
PHYSICIAN'S NAME (Type) <u>P. E. C. M. D.</u>		ADDRESS (Street, city or town, state) <u>Easton Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sandlun Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Hillsboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Woodell</u>		24a. REC'D BY REGISTRAR <u>Aug 27 '59</u>	
ADDRESS <u>Easton Md</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Knead</u>	



9574

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>			
c. LENGTH OF STAY IN 1b <u>6 hrs-20 min</u>				d. STREET ADDRESS <u>RFD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Essie Mae Thomas</u>				4. DATE OF DEATH Month Day Year <u>August 28, 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/1910</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Will Connley</u>				14. MOTHER'S MAIDEN NAME <u>Edna Connely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes: no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Carrie Owens, Easton, Md.</u>			
17. INFORMANT Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>8-28</u> , 19 <u>59</u> , to <u>8-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-28</u> , 19 <u>59</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D. <u>202 Dover St.</u>				<u>8-30-59</u>			
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>				<u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Palmetto Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Palmetto Fla.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Williams</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Day 2: Mid Week

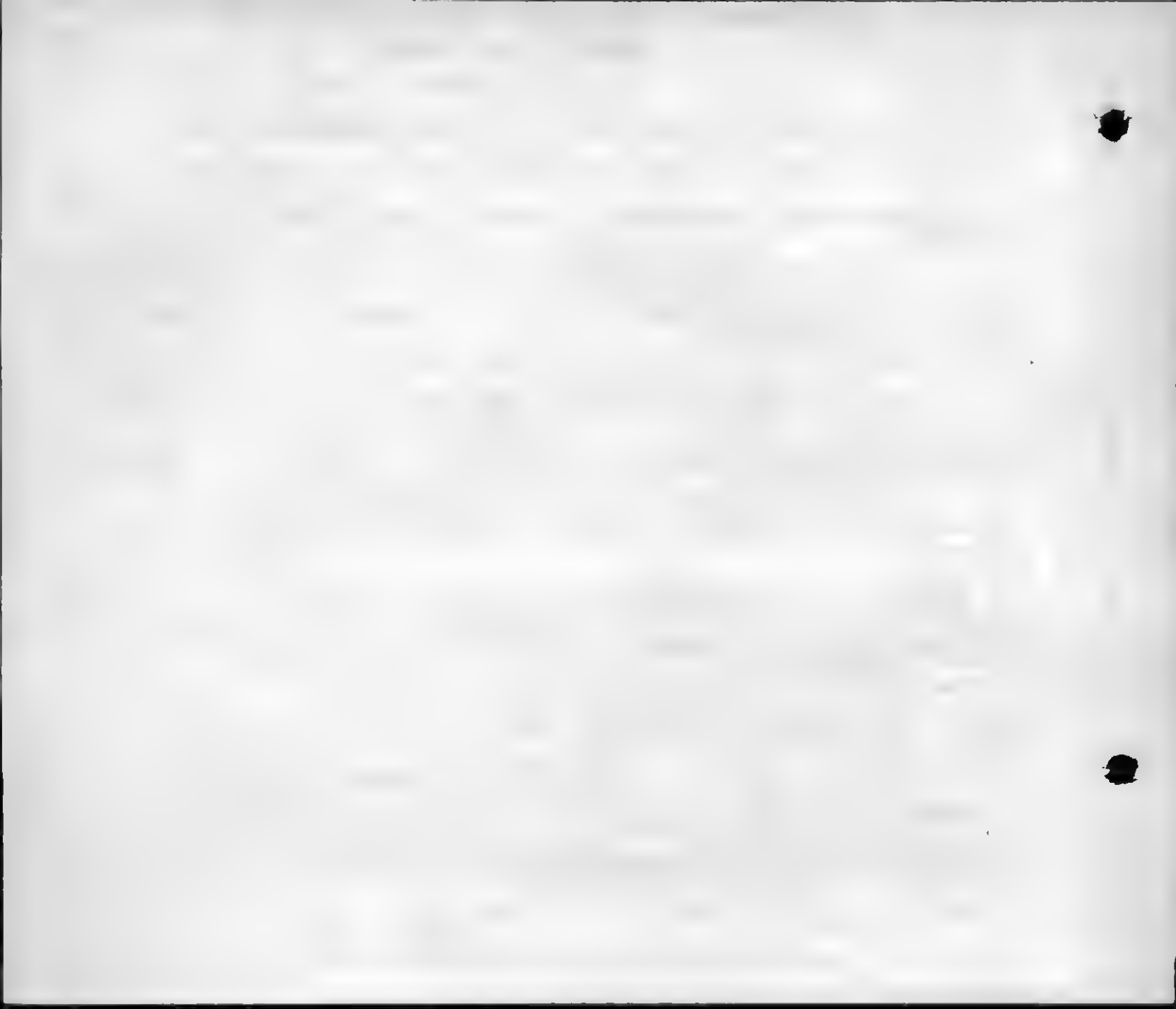
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9573 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

09555

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <u>Maryland</u> o COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>32 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>Freemont St</u>	
3. NAME OF DECEASED (Type or print) First <u>Pierre</u> Middle <u>Liamotte</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7 1959</u>
9. AGE (In years last birthday) <u>32</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>32</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lieewood Leon Fountain</u>		14. MOTHER'S MAIDEN NAME <u>Matthe Virginia Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO <u>prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>prematurity</u> DUE TO (c) <u>prematurity</u> INTERVAL BETWEEN ONSET AND DEATH <u>32 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-7-59</u> , 19 <u>59</u> , to <u>8-9-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-9-59</u> , 19 <u>59</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm M Freese</u> M.D.		ADDRESS (Street, city or town, state) <u>Freemont St Easton Md</u>	
PHYSICIAN'S NAME (Type) <u>Wm M Freese</u>		DATE SIGNED <u>8-11-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>8/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hsp</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Harris</u>		ADDRESS <u>Freemont St Easton Md</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9576

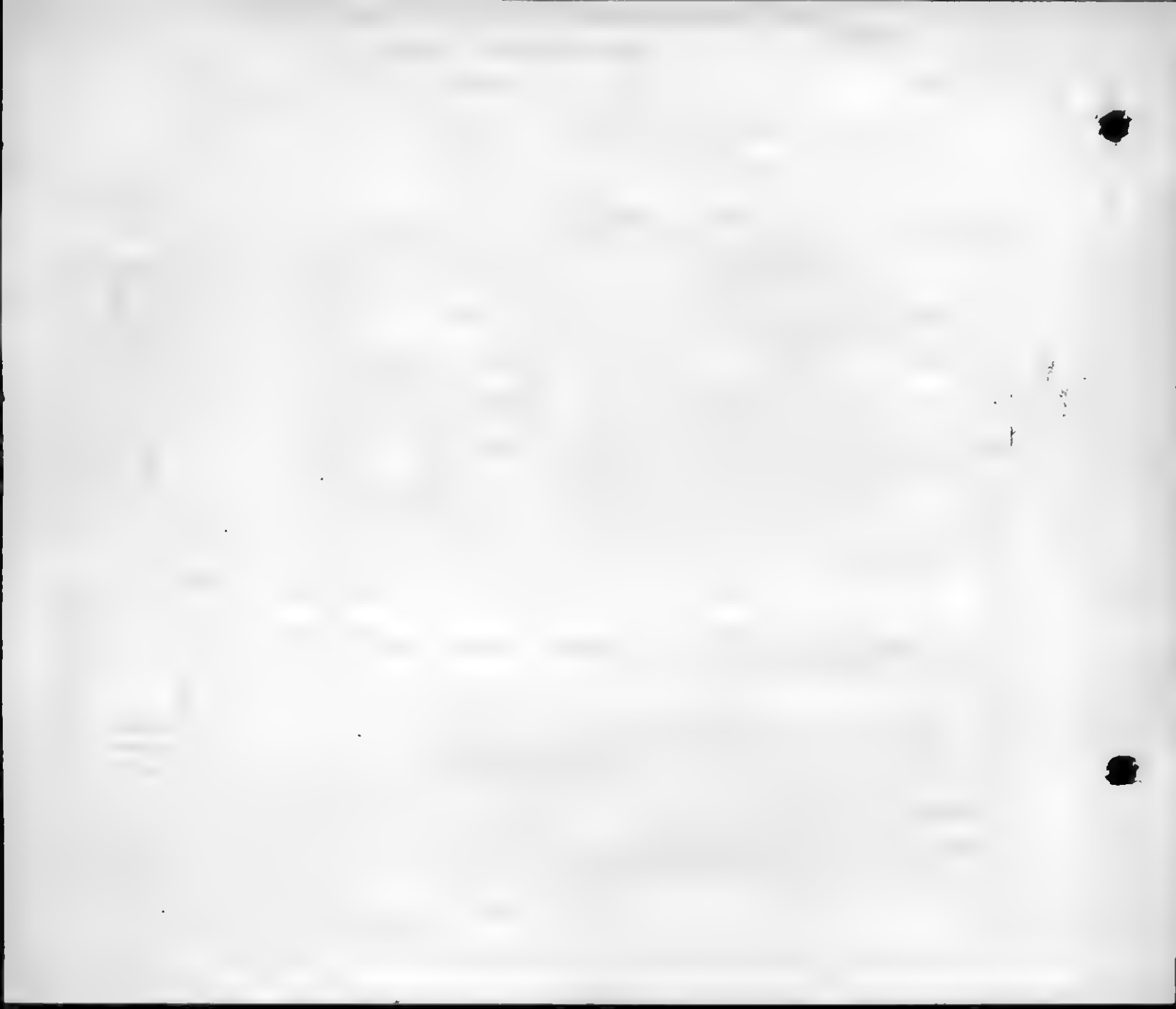
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09558

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>A</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 9 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph Cherry</u>				14. MOTHER'S MAIDEN NAME <u>JANE Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Clarence Ringgold</u> Address <u>Ridgely, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u>							<u>36 hr.</u>
DUE TO <u>Left cardiac thrombosis</u>							<u>5 wks</u>
DUE TO <u>Coronary thrombosis & myo-cardial infarction</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3 Aug</u> 19 <u>59</u> , to <u>4 Aug</u> 19 <u>59</u> , that I last saw the deceased alive on <u>4 Aug</u> 19 <u>59</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				DATE SIGNED <u>6 Aug 59</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Aug 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greenboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Virgil Brown Son</u> ADDRESS <u>Verdora, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9577

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09557

1. PLACE OF DEATH a. COUNTY <u>TALBOT CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md.</u>		c. LENGTH OF STAY IN IB <u>25 min.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		d. STREET ADDRESS <u>201 Belvedere St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Asa</u> Last <u>Voshell</u>		4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Smith Voshell</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Walls</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-30-8237</u>	
17. INFORMANT <u>Mrs. Edward Voshell</u>		Address <u>Centerville</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>a. H. D</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>stroke several yrs ago</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> to <u>8/2/1959</u> , that I last saw the deceased alive on <u>8/2/1959</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. E. Cox</u>		DATE SIGNED <u>8/3/59</u>	
PHYSICIAN'S NAME (Type) <u>P. Evans Cox</u>		<u>Easton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Aug 4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR <u>August 7 '59</u>	
ADDRESS <u>Church Hill</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>	

CERTIFICATE OF DEATH

DATE

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is filled out with handwritten text.

DECEASED
Name: John Doe
Age: 45
Sex: Male
Race: White

RESIDENT
Address: 123 Main St, Baltimore, MD

CAUSE OF DEATH
Immediate Cause: Heart Disease
Underlying Cause: Coronary Artery Disease
Manner of Death: Natural

PLACE OF DEATH
Home: ☒ Hospital: ☐ Other: ☐

SIGNATURES
Physician: [Signature]
Registrar: [Signature]



Vertical text on the right margin, possibly a filing or archival note.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9578

CERTIFICATE OF DEATH

Reg. Dist. No. 09558

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>				d. STREET ADDRESS <u>Bozeman</u>			
3. NAME OF DECEASED (Type or print) First <u>MRS. Lottie</u> Middle <u>M</u> Last <u>Watson</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Mr Robert Lloyd</u>				14. MOTHER'S MAIDEN NAME <u>Martha Brookman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Percy F. Watson, son</u>				Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>422.1</u> DUE TO <u>atherosclerotic cardio vas. d.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia, cerebrovascular occluded.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8-1-59</u> , to <u>8-17-59</u> , that I last saw the deceased alive on <u>8-17-59</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>St Michaels MD</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8-12-59</u>			
PHYSICIAN'S NAME (Type) <u>Larry M Reeser MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 20 1959</u>		<u>Graham Cemetery</u>		<u>Orange, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stamilton Harrison, St Michaels MD</u>				24. REC'D BY REGISTRAR <u>19 59</u>			
ADDRESS				25. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

9577

CERTIFICATE OF DEATH

1954

[Faint, mostly illegible handwritten text on a death certificate form. The form includes fields for name, date of birth, date of death, cause of death, and place of death. The handwriting is very light and difficult to decipher.]